CENTERS FOR DISEASE CONTROL AND PREVENTION

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OFFICE OF MINORITY HEALTH AND
HEALTH Equity
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HEALTH DISPARITIES SUBCOMMITTEE

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THURSDAY
FEBRUARY 2, 2017

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The Subcommittee met by teleconference at 1:30 p.m., Lynne Richardson, Chair, presiding.

PRESENT
LYNNE D. RICHARDSON, M.D., Chair
ANTHONY ITON, M.D., J.D., M.P.H., Senior Vice President, Health Communities, The California Endowment
DAVID FUKUZAWA, M.Div, M.S.A, Program Director for Health, The Kresge Foundation
MARY GARZA, Ph.D, M.P.H, Assistant Professor, University of Maryland School of Public Health
GARTH GRAHAM, M.D., M.P.H., President, Aetna Foundation
MARGUERITE RO, Dr.P.H., Chief, Assessment, Policy Development, and Evaluation Section, Public Health, Seattle-King County
WILL ROSS, M.D., M.P.H., Associate Dean for Diversity, Washington University School of Medicine
HECTOR VARGAS, Executive Director, Gay and Lesbian Medical Association, Health Professionals Advancing LGBT Equality

CHERI WILSON, M.A., M.H.S., CPHQ, Director, Diversity and Inclusion, Robert Wood Johnson University Hospital
WILMA WOOTEN, M.D., M.P.H., Public Health Officer, County of San Diego Health and Human Services Agency

ALSO PRESENT
MELANIE DUCKWORTH, Ph.D, Senior Advisor to the Director, Office of Minority Health and Health Equity
JEFFREY HALL, Ph.D, MSPH, CPH, Behavioral Scientist, Etiology and Surveillance Branch, Division of Violence Prevention, National Center for Injury Prevention and Control
DAVID HUANG, NCHS, Ph.D., M.P.H., C.P.H., Office of Analysis
LEANDRIS LIBURD, Ph.D.,M.P.H., Designated Federal Officer
ANA PENMAN-AGUILAR, Ph.D., Associate Director for Science, Office of Minority Health and Health Equity
JUDY RICHARDS
ANNE SCHUCHAT, M.D., Acting Director CDC/ATSDR

C-O-N-T-E-N-T-S

P-R-O-C-E-E-D-I-N-G-S

1:31 p.m.

DR. LIBURD: So good afternoon, everyone. This is Leandris Liburd. I am the Designated Federal Officer for the Health Disparities Subcommittee, and I will go ahead and start our meeting with the official roll call. Please indicate if you are present when I call your name. Lynne Richardson?

CHAIR RICHARDSON: I am present.

DR. LIBURD: David Fukuzawa?

MR. FUKUZAWA: Present.

DR. LIBURD: Mary Garza?

(No audible response.)

DR. LIBURD: Garth Graham?

DR. GRAHAM: Present.

DR. LIBURD: LaMar Hasbrouck?

(No audible response.)

DR. LIBURD: Willie Horner Johnson?

(No audible response.)

DR. LIBURD: Anthony Iton?

(No audible response.)

DR. LIBURD: Maureen Lichtveld?

(No audible response.)

DR. LIBURD: Marguerite Ro?

MS. RO: Present.

DR. LIBURD: Will Ross?

MR. ROSS: Present.

DR. LIBURD: Mildred Constance?

(No audible response.)

DR. LIBURD: Hector Vargas?

MR. VARGAS: Present.

DR. LIBURD: Donald Warne? Don?

(No audible response.)

CHAIR RICHARDSON: He might be muted.

DR. LIBURD: Okay. Are you on mute?

(No audible response.)

DR. LIBURD: Okay. We know he is here.

PARTICIPANT: Yes, I thought I heard him come on earlier.

DR. LIBURD: Yes, he did. Cheri

Wilson?

MS. WILSON: Here.

DR. LIBURD: Wilma Wooten?

MS. WOOTEN: Here.

DR. LIBURD: I am going to go back and double-check that Mary Garza --

MS. GARZA: Here.

DR. LIBURD: LaMar Hasbrouck?

(No audible response.)

DR. LIBURD: Willie Horner Johnson?

(No audible response.)

DR. LIBURD: Anthony Iton?

MR. ITON: I am here.

DR. LIBURD: Okay. Great. So --

CHAIR RICHARDSON: Would you read for us Leandris who you have as present?

DR. LIBURD: Yes. So I have Lynne Richardson, David Fukuzawa, Mary Garza, Garth Graham, Anthony Iton, Marguerite Ro, Will Ross, Hector Vargas, Don Warne, Cheri Wilson, and Wilma Wooten.

CHAIR RICHARDSON: Are there any HDS members whose name Leandris did not just call who are on the line?

(No audible response.)

DR. LIBURD: So we -- we have a quorum, and we can begin the meeting, and if any Health Disparities Subcommittee members join, please let us know at a different point on the agenda.

CHAIR RICHARDSON: Okay, Leandris. Could we just give an opportunity for any CDC staff or members of the public who are on to identify themselves?

DR. LIBURD: Yes. So we can start in this room. This is Leandris Liburd, and I am here with Melanie Duckworth. So who is on the phone?

MR. HALL: This is Jeff Hall.

MS. RICHARDS: Judy Richards here. Oh, sorry.

DR. LIBURD: Okay. Dr. Anne Schuchat

has just joined.

DR. SCHUCHAT: Good morning.

DR. HUANG: Hi. This is David Huang from NCHS.

DR. LIBURD: David, great, good morning -- I mean afternoon. Anyone else?

(No audible response.)

DR. LIBURD: Okay. Great.

CHAIR RICHARDSON: Okay. Thank you, Leandris.

So I -- I did hear that Anne Schuchat is on the phone, so to be respectful of what I can only imagine is her very busy schedule, I think we're going to move right to an update on the transition from Anne, and thank you so much for joining us.

DR. SCHUCHAT: Well, thanks so much for inviting me, and thank you for all that you do. I was really pleased to get to meet with the subcommittee last year when you were in town for the last meeting in my role as Principal Deputy

Director, and I am pleased to get to join you by phone today in my new role.

I wanted to share with you some of the internal changes that reflect our temporary -- you know, our transition status. In addition to my serving as the Acting Director for CDC, Pattie Simone has joined us as the Acting Principal Deputy Director. I think many of you will know Pattie from her work leading the division that is focused on training and workforce and her prior work as Principal Deputy Director for our Global Health Group, so she brings a huge amount of experience to our leadership team here.

And then also I'll let you know that Sarah Wiley has joined as the Acting Chief of Staff for CDC. She is usually the Senior Advisor in the Office of Infectious Diseases here, and those of you on the Advisory Committee to the Director will probably remember Sarah, as she served as the Designated Federal Official for the Laboratory Safety Working Group to the Advisory

Committee to the Director, so Sarah will be Acting Chief of Staff and also in that role serving as the Designated Federal Official to the whole Advisory Committee to the Director.

You know, the team -- the others that you were familiar with remain in place, with Katherine Lyon Daniel as the Lead for Communication and Sherri Berger as our Chief Operating Officer. Karyn Richman is now the Acting Director for our CDC Washington office, and Von Nguyen is leading the Office of the Associate Director for Policy, as John Auerbach moved on to the Trust for America's Health, so it's a great team, and we are all interim except for the people who were here before us, but we're very pleased to get to work with our advisory committees and subcommittees on the Agency's key work.

You know, from my perspective, there is a lot of really good work that the Agency has been doing recently on health disparities and

equity issues. I hope you saw the January Vital Signs that was focusing on improvements in chronic renal disease among diabetics who are American Indian or Alaska native. We have had actually great progress in the chronic renal disease sequelae among people with diabetes in the tribal communities, and so that was actually a good news story about using best practices and models that could be used in other areas.

We also had a recent MMWR really highlighting rural health and some of the really shocking disparities that were seen in rural areas around the country. That was a surveillance summary in the January -- in January for the MMWR, but it was launching a yearlong set of articles about rural health issues, and so that -- one of the equity issues that we really want to be highlighting right now is we have uncovered pretty exceptionally high rates of mortality in rural populations.

Next month, we're going to be --

actually, this month, wait a minute, February, we're going to be highlighting hearing loss as a major health problem that hasn't gotten that much attention, and that has been a partnership across multiple centers here, but again one where there are some important disparities that we will be signaling. So I think the scientific and programmatic work is continuing, and with high visibility - that is, as highly visible as we can have.

In terms of the information about the transition, I would say that before a Secretary is appointed for HHS, we are pretty much in a holding pattern. I have had several meetings with first the transition team, and now with the incoming -- a small number of staff at the Department of Health and Human Services, but they are really focused on organizationally getting set up and looking -- I would say their priority right now is really looking at regulations that are recently released and not yet implemented or

about to be released so that they can take a look at those. So we don't have a whole lot of direction yet about priorities other than what you can see in the media in terms of the issues related to health reform.

My position as Acting Director is, you know, personally an incredible privilege, and since I have been at CDC for 29 years, it is really kind of exciting to get to do this and represent the Agency and mainly, support the good work going on here, but I don't have information about how long I will be in this role. The key message for you all is that the folks you have been working with are still here, and we are still committed to work closely with you and get the advice that you have.

I wish I knew more, but what I promise to folks inside the Agency and also want to share with partners and advisors is that as I know more, I hope to be able to update people as fully as I can, so that is kind of my -- what I can

tell you, but I am happy to try to answer questions if you have any.

CHAIR RICHARDSON: Thank you so much for that, Anne. Are there any questions from any members of the committee?

MR. ROSS: This is Will Ross. Dr. Schuchat, thank you. We are privileged to have you here, even in an acting capacity, so thank you.

So in terms of the briefing, the Trump administration, do you have to wait until the Secretary is confirmed, or have you had opportunities to do so beforehand?

DR. SCHUCHAT: We -- we have been able to do the high-level what is CDC, and they had requested some -- the transition team had requested some particular briefings on public health emergencies and how we had dealt with them in the past, for instance Ebola and the pandemic, and there was a separate briefing on Zika so they would know what the situation was and what to

expect, so that was with the transition team prior to the inauguration.

Since the inauguration, there is something called a beachhead team that is set up at Health and Human Services, some individuals who are going through a Senate confirmation type process, and they are really in the catcher's mitt mode right now of just trying to learn what are the actions of the week that they need to know about, and so I have had a couple video conferences with them, but it's not yet at the point of setting priorities or direction.

MR. ROSS: Okay. Thanks.

MS. RO: Hi. This is Marguerite Ro, and Dr. Schuchat, again, thank you for taking the time out of your day to join us.

So we are hearing a lot I think in the media about the potential for the repeal of the ACA, and I am just wondering whether or not -- because I don't recall whether or not the CDC Office of Minority Health and Health Equity was

created under the ACA or whether or not we had that prior to the ACA, and just wondering about what potential impact on funding for the office?

DR. SCHUCHAT: I believe that our office predated the Affordable Care Act. Our positions were there before that. The funding for the office activities doesn't come through the Affordable Care Act funding. Our Agency does get funds that are called the Prevention and Public Health Fund which actually account for more than 10 percent, I believe it's 12 percent, of our Agency's budget.

The Prevention and Public Health Fund was part of the Affordable Care Act, and so there has been some concern that appeal of the Affordable Care Act would impact that fund. The funds are actually used for core or base activities and are not related to health reform, and so that we've been able to signal that for instance to the transition team that funding is separate from exchanges and so forth.

But the budget horizon really remains to be seen. I think that in terms of the executive orders that have already been publicly made, I think we all really need to be ready for some budget uncertainty and some challenging federal budget times, but I don't have specific information about that. In terms of the office setup, though, we believe that predated the health reform bill.

DR. RO: Thank you.

CHAIR RICHARDSON: Other questions?

(No audible response.)

CHAIR RICHARDSON: Really? I am very surprised at this group, although I think we all appreciate that, as you say, we all have to be prepared for a certain level of uncertainty in a number of arenas.

With respect to at least the -- sort of the immediate workings of this committee, do you anticipate that we will meet as usual in the spring in CDC, that all of that is sort of on

automatic pilot until there is a change, or is it in limbo until there is clear direction?

DR. SCHUCHAT: Thanks for raising that. I had meant to include that in my remarks. We will be sending a communication out to the Advisory Committee to the Director members soon. We were able to speak with the chair, David Fleming, yesterday to talk a little bit about that.

I think the thinking is we have great members of the ACD and very busy schedules, and everybody has held that date in April for the next meeting, so we didn't really want to release it right now. In the back of our minds, though, there was the idea that perhaps if we know that we will have a new Director in place, you know, for instance by May, it might be nice to delay the meeting a little bit so that the committee could meet with the new Director. When will we know that? Who knows?

So what we have decided is to keep the

April date for now, to poll people about possible dates in May, but for the time being really plan to go ahead so that we can benefit from their advice. The thinking is that a new Director would benefit from meeting with the advisory committee and vice versa, but if we have an extended period of interim leadership, it would be a great time to hear their perspectives. So I think the meeting planned for April, for now, we're planning to go ahead with it, but it will be a little bit clearer in the message that we send out soon.

CHAIR RICHARDSON: Okay. So stay tuned, but at this point, we should all leave those dates on our calendars, okay.

I did hear someone else join. Did a member of the Health Disparities Subcommittee just call in?

(No audible response.)

CHAIR RICHARDSON: Okay. Perhaps it was someone else. Any other questions for Dr.

Schuchat?

(No audible response.)

CHAIR RICHARDSON: Well then, again, I would like to thank you. We are very appreciative that you did take the time to join us telephonically. We really do appreciate that and do take your participation today as a sign of the importance that the work of this subcommittee holds for you, and we are very appreciative of that support, and we look forward to doing whatever we can to support you in your role as Acting Director and then as we all move forward into this brave new world.

DR. SCHUCHAT: Well, let me just thank you, Lynne, and thank the whole subcommittee. I really appreciate what you do outside and what you do for us on the subcommittee. You know, we get really good advice from our advisory group, and it helps us make sure we are on track, so thanks for the time that everybody is putting into this, and

Leandris, thank you for your leadership of the group.

CHAIR RICHARDSON: Absolutely. I would like to second that shout-out to Leandris.

Okay. Well, with that, I guess we will release you to go on with what I am sure is a very busy day, and we will move on with our agenda. So I don't have too much in the way of opening remarks, and Leandris, is your update on here anywhere, or is it --

DR. LIBURD: Yes, it is, and I do have one thing I wanted to share with the subcommittee in terms of an update, which is that we are in the throes of planning our third annual Public Health Ethics Forum in collaboration with Tuskegee University. This year, we are going to do it in May. It will be May the 19th, and the theme will be around women's health and women's health across the life cycle, and so, stay tuned. We will be sharing more. It will be here in Atlanta at the Global Communications Center.

One of the things I want to just raise, put on the radar for our academic colleagues is that we will be reaching out to academic institutions this time I think in a more targeted way, a more concerted way, to encourage students to participate virtually. We are hopeful that faculty will support their participation by maybe providing some academic credit, having them do some follow-up assignment based on presentations or panels or some of the information that will be coming forward through the forum.

So that is my primary update for today, and you will be hearing more from us about this. And --

(Simultaneous speaking.)

DR. ROSS: Hi --

DR. LIBURD: -- any questions --

DR. ROSS: -- Leandris, this is Will.

DR. LIBURD: Yes.

DR. ROSS: Regarding prospective

members for HDS, I know you had asked for our input. I submitted some names. What is the time period for actually identifying and having HDS members brought on board? I presume we are talking after May sometime, right?

DR. LIBURD: Right. Yes, we are getting names and resumes right now along with a letter of recommendation that also comes with the nomination, and we will be making a decision let's say in May because the members who are rotating off and those whom we cannot extend, their term ends on June 30th. To give us time to go through all of the processes of onboarding subcommittee members, we are accepting their information and nominations now, and hope to have people committed by the end of May.

CHAIR RICHARDSON: I would like to point out, and correct me if I am wrong, Leandris, that current members, even if their terms are due to end in June, continue to serve until their successors are duly appointed and approved. Is

that correct, Leandris? I think they went over that at an ACD meeting.

DR. LIBURD: Okay. Yes, I know --

CHAIR RICHARDSON: I just don't want people to think they are going to be allowed to disappear June 30th if we have not yet gotten the new members processed, which I assume may have to await a new Director. I don't know. I don't know if that is something that can happen during the transition.

DR. ROSS: My daughter is trying to make me hip, and they said the new word is ghost rather than disappear.

(Laughter.)

CHAIR RICHARDSON: I see. Thank you for that.

DR. ROSS: Sure.

DR. LIBURD: Okay. I can certainly confirm that. I think members can be extended for up to 180 days with approval.

CHAIR RICHARDSON: Well, I thought

that they continued until their successor was confirmed, but there was a limit to how long that could happen. Perhaps it's a year. I don't know if everyone actually knows when their term is expiring or who would be rotating off come June, but I would hate to lose momentum because we lose a significant number of our current members and for whatever reason the new members are not yet processed and approved and appointed.

DR. ROSS: Lynne, that was my point also. I just was concerned we were going to lose something in the transition.

CHAIR RICHARDSON: Yes, so --

DR. ROSS: Take a look at that.

CHAIR RICHARDSON: Yes, we will look into the legalities of that and get back to you so that people can sort of know what to expect in terms of whether their service might be continuing past June 30th. I think it would be extraordinarily ambitious to believe that we would have everyone confirmed and appointed by

June 30th, although perhaps it would be possible before we met in the fall.

DR. LIBURD: Yes, and I can certainly let everyone know their term. We're in the process now of extending several members for another two years. They are aware that they are being extended.

CHAIR RICHARDSON: Reappointed? Yes.

DR. LIBURD: Yes, and then we can let the members know. Some members have served three terms, and we can't extend them any more.

CHAIR RICHARDSON: Right.

DR. LIBURD: We'll let those members know as well, and I have actually spoken with a couple of members about their interest in continuing because yes, I do think the consistency is important. I think that this has been an incredibly productive subcommittee, and we certainly don't want to lose any of our momentum.

CHAIR RICHARDSON: Absolutely. Okay. So thank you for that, Leandris. So I don't really have much in the way of opening remarks. I think this is a particularly challenging time for those of us who care about health equity specifically and equity in general. I think it is going to be very important for us to think strategically and work collectively to make our efforts to preserve and promote the work that is so important to all of us continues.

I think this will be even more challenging than it has been in the past. I think that makes our work even more important and our role as members of a federal advisory committee, again, really very important as a platform that will allow us to observe the impact of various actions and initiatives on the health of the public, and particularly on the diverse populations that are the focus of this committee.

So I want to thank you for the work you have done and really issue a call to action

for the work that we will now have to do that I think will require certainly vigilance and diligence, perhaps courage, as we continue to work on the things that are important to us. It has been a real pleasure working with all of you, and I look forward to continuing the effort.

I will give anybody else a minute if anybody wants to say anything or make any general remarks, but I do want to keep us on time, and I know we're going to have an update on the diversity culture audit that was done at CDC next on the agenda. But does anyone want to make any response? You could just say ''amen'' or ''ashe'' or whatever you're feeling.

DR. WOOTEN: Lynne, this is Wilma Wooten. I don't know if this is the time, Leandris, to bring up the issue that I emailed you about, but it kind of speaks to future and continuation of our efforts.

The --

CHAIR RICHARDSON: So Wilma, I think

I know where you're going. I think we actually are going to bring that up later in the agenda -- -

DR. WOOTEN: Okay.

CHAIR RICHARDSON: -- because that is definitely more than a one-minute conversation.

DR. WOOTEN: All right. Thank you very much.

CHAIR RICHARDSON: Absolutely, thanks. Anybody else?

(No audible response.)

CHAIR RICHARDSON: Okay. Is Dr. James Nelson on the line?

DR. LIBURD: So Lynne, this is Leandris.

CHAIR RICHARDSON: Yes?

DR. LIBURD: I was just told that Dr. Nelson had a family emergency that has caused him not to be able to join us today.

CHAIR RICHARDSON: Oh, I am sorry to hear that.

DR. LIBURD: Yes, I am too. We just heard about it just within the last 15 minutes, so we will, with your permission, go on to our next presentation --

CHAIR RICHARDSON: Yes, okay.

DR. LIBURD: -- by Ana.

CHAIR RICHARDSON: Okay. So we are now moving to the update on the Workforce Diversity Indicator activity. You all will recall that the CDC was working with the National Collaborative for Health Equity on what I believe was a Robert Wood Johnson-funded effort to look at this, if I have that correctly. But whether I do or not, we will now hear from Ana Penman-Aguilar to tell us the status of that activity.

DR. PENMAN-AGUILAR: Thank you, Lynne.

There are a couple different aspects to this presentation. One is related to the workforce diversity indicators that we are developing at CDC. The other aspect is more

broad, and so I will start with that, and that relates to the National Collaborative for Health Equity.

As Lynne mentioned, they are funded by Robert Wood Johnson to develop measures, and it's a broad health measurement activity, so it covers many domains. It covers health outcomes both for children and for adults. It covers income, education, employment, physical environment, social environment, housing, safety, and access to quality healthcare, so this is a bit distinct from the workforce diversity indicator discussion, so I will start with this.

So in response to the recommendation from the subcommittee that we develop indicators of health equity, we did an environmental scan of efforts across the country that were doing similar things, and we were very excited by the work of Brian Smedley's group within the National Collaborative for Health Equity, their work on the Health Opportunity and Equity Measures

project.

So as was mentioned earlier, Dr. David Williams, he is on the advisory committee, and I believe he is the chair. I am also on the advisory committee, and we at CDC have been doing a lot of back-and-forth with the project, connecting -- David and I have been connecting -- he is on the call, David Huang, and I have been connecting them with SMEs, subject matter experts, for the data sources that they're using in their projects, because they're using a lot of CDC data.

So just to give you a little background, and I did send out a one-pager, the project has been launched to start a new conversation about the opportunity gap to develop metrics that can be used to chart progress toward health equity, so the primary goals are to reframe the health disparities conversation in the context of health equity and opportunity and to develop a set of broadly accessible measures

to illustrate gaps and opportunities to achieve health outcomes.

So this is one of the things that was particularly appealing to us about this project, that it really took a new -- a different look at disparities, not in terms of deficits in health, but in terms of opportunities, and it's also multisectoral in its approach because experts tend to focus on inequities in their field and miss how solutions are interconnected.

So the National Collaborative for Health Equity will be developing a framing document that lays out the theoretical framework, a state-level analysis that identifies the magnitude of relative and absolute disparities in health outcomes, and a national-level report that depicts opportunity gaps across the country.

So I will pause to see if there are any questions on this particular aspect of the presentation.

(No audible response.)

DR. PENMAN-AGUILAR: Okay. And I will also add that the idea is that we hope to add value to the collaborative, but we certainly expect that what the collaborative learns and develops will be of use to the CDC, and that's the goal - to identify things that they are doing that we may want to incorporate in our work here at CDC.

CHAIR RICHARDSON: Ana, is there any more detail on the timeline for specific types of measures?

DR. PENMAN-AGUILAR: Well, they have done a teaser analysis, so the principal actors have done a teaser analysis, and that was of several indicators of health outcomes, income, and social environment, and that confirms the methodological approach. It showed that they were able to share findings for each indicator and build an indicator profile for a state, and show regional patterns. But in terms of the timeline for the overall project, all I really know is

that we're talking about within this calendar year.

CHAIR RICHARDSON: Okay. Thank you. Are there other questions for Ana?

DR. ROSS: Yes -- this is Will Ross again. I appreciate this much more egalitarian approach on opportunity, an access-based approach. I think it's much more positive.

I wanted to hear that, while we are doing this, we're still ensuring there is true intersectionality in designing this framework, and intersectionality relates to our policy advocates and people with the National Centers in D.C., people like Nadine Gracia and others, and so do we feel that we have the right personnel from the policy framework to help drive this? I know you mentioned David Williams, but you didn't mention anyone else.

DR. PENMAN-AGUILAR: Oh, it's an impressive list of folks. I wish I could remember more names off the top of my head.

CHAIR RICHARDSON: It's on their website, I think.

DR. PENMAN-AGUILAR: It is, it is.

MR. ROSS: I will go online. Don't worry, I will look for it.

DR. PENMAN-AGUILAR: Certainly with David being represented, I can't imagine that intersectionality will be neglected, since he is, very much the person who has advanced intersectionality.

We will be looking at ranking indicators by race, ethnicity, income, education, and place, and so there are the ingredients for a robust intersectional look at things.

DR. RO: Well, this is Marguerite, and I think this is really great and exciting work, and I think the finding of opportunity is one that also gives hope.

I will say that there are so many efforts right now going on around data dashboards and such indicators, and particularly ones that

are at a lower level, you know, that address either the county level, or for instance, the Big Cities Health Coalition that NACCHO organizes has developed a data dashboard for big cities, and while I think it is helpful to have the state view, really a lot of the innovation and the need to address opportunities happens at a very local level. To the degree that the work can connect to what is happening at a more disaggregated level, I think the better off we will all be.

DR. PENMAN-AGUILAR: Yes, and there is also work happening in HHS related to Public Health 3.0, which is also more focused at a community level, so we will have a meeting in April, and I will definitely bring that perspective, and I can bring back information from that meeting.

MS. WILSON: Ana, this is Cheri Wilson. I had a quick question: how do you -- I think maybe many of us have heard about the two new bills in the House and Senate that have been

proposed that would block federal funds for a federal database on geospatial information to identify community racial disparities. So Marguerite, getting back to what you just said, do we have any idea how that can potentially adversely impact data collection or looking at those data?

DR. PENMAN-AGUILAR: I haven't seen that information and I don't have an answer for you.

MS. WILSON: Okay.

DR. PENMAN-AGUILAR: Yes.

MS. WILSON: Leandris, would you like me to send that out to you or someone to distribute to the HDS as something to look at?

DR. LIBURD: Yes, that would be good. Thank you.

MS. WILSON: Okay. It's all over the public health list servs, so thank you.

DR. LIBURD: I just wanted to add to Will's question --

CHAIR RICHARDSON: It's a little bit hard to hear you, Leandris.

DR. LIBURD: Okay. I just wanted to add in response to Will's question about policy indicators and the HHS Office of Minority Health, they are aware of this activity, very, very interested in it, and I believe they are waiting to have it evolved further before really reaching out to Brian Smedley and his group separately and his collaborators to talk more about policy outreach.

DR. ROSS: Thanks, Leandris.

DR. RO: This is Marguerite, I am thinking about the indicators… I don't know if it would work for Healthy People 2030 because it isn’t done yet, but it would be interesting to make sure that this work also helps to inform that next effort.

DR. PENMAN-AGUILAR: Right, and it has begun, and Leandris has been at the center of it, so there will be plenty of opportunity for

conversation within the office that can then feed the work of Healthy People 2030.

Okay. So I am going to move on to the presentation about indicators of health and healthcare workforce diversity.

CHAIR RICHARDSON: Workforce diversity, thank you.

DR. PENMAN-AGUILAR: So each of you should have a slide set in email, and I would like you to open it, please. And I will try to remember to ask you to advance slides.

So starting with the first slide which you see.

CHAIR RICHARDSON: And Ana, it is becoming a little hard to hear you.

DR. PENMAN-AGUILAR: We're just doing some technical things in the room here to make sure that you can hear me and that I can view the slides.

(Pause.)

DR. PENMAN-AGUILAR: So on the second

slide, you see a list of folks on the workforce diversity indicator team, and this has been a wonderful and very rewarding effort. This has just been fabulous to have the work of Brittany and Jeff Hall, who is the Deputy Associate Director for Science; David from NCHS; Ramal Moonesinghe, mathematical statistician; myself.

The presentation will include problem statement, et cetera. We're on the problem statement slide.

So this represents some of the work of our literature review and things that those of us on the phone are well aware of, so it is important that the workforce adequately reflects the population served. We know that by 2042, the country is expected to become majority minority.

CHAIR RICHARDSON: Ana, I know I'm having problems --

DR. PENMAN-AGUILAR: Okay.

CHAIR RICHARDSON: -- hearing. That

is much better.

DR. PENMAN-AGUILAR: All right. Okay. Now I have two microphones.

As I just said, we know that by 2042, the country will be majority minority, yet racial ethnic minority groups remain underrepresented in health and healthcare workforces, so we expect that health disparities will increase if workforce representation does not improve, and we have noticed that for workforce diversity measurement and monitoring, the national and sub-national indicators are limited.

And tying this to CDC's mission, our mission is to work 24/7 to protect America from health, safety, and security threats, and this involves routinely taking the pulse of our nation, and this includes social determinants of health and other determinants of health disparities.

So the purpose of this project is to improve understanding of diversity in the U.S.

health and healthcare workforce; assess the state of diversity; expose measurement gaps; frame diversity as a social determinant of health that must be addressed to advance health equity. So for this reason, we are developing indicators of diversity through a health equity lens.

This actually builds on a workforce diversity indicator that was developed for Healthy People 2010, and it complements the social determinants of health indicators that are in Healthy People 2020, and we anticipate that it will complement the indicators in Healthy People 2030.

This slide shows you that in Healthy People 2010, there was an indicator of diversity, and Dr. David Huang, who is on the call, actually worked on this indicator. It was based on the proportion of members of underrepresented racial and ethnic groups specifically. For example, this slide shows the number of degrees awarded by accredited allopathic medical schools to AIAN

Native persons, so this is one element in the objective. Next slide.

So we anticipate that this will help -- it will lead to understanding the state of health and healthcare workforce diversity, encouraging actions to improve diversity, and perhaps more importantly, promoting better-focused actions to improve diversity. It will lead to understanding gaps in what can be assessed, encouraging collection of new data elements, and I should add perhaps new methods for combining data elements to really look at intersectionality promoting consideration of health and healthcare workforce diversity as a social determinant of health. This is also one of the goals.

And ultimately, this benefits the public because there will be a health and healthcare workforce that is better-equipped to improve health, and we expect to reduce health disparities. Next slide, please.

We have conducted an environmental scan of datasets measuring health and healthcare workforce diversity. Brittany, who is on the call I believe, has worked with Jeff to develop an annotated bibliography. She also developed two justification statements, and we have been conducting key informant and stakeholder consultations.

And in terms of what is ahead, we intend to keep consulting with informants and stakeholders as we develop workforce diversity indicators. We are starting with a teaser indicator for a diverse workforce. Brittany is putting together a spreadsheet of all the different data sources, and we're looking at the strengths and weaknesses of those, and we're thinking about methods for combining data points.

And then it will expand to other dimensions of the healthcare workforce. Once we have learned what we can learn from this process, we'll expand to the public health

workforce, which will be a bit more challenging, and then once we have the indicators developed, we will measure workforce diversity and produce a report with a gap analysis in this calendar year. Next slide, please.

So I wanted to talk a little bit about what we have learned, and I think having Dr. Jeff Hall and Ms. Brittany Ashkenazi on our team has been good because it has allowed us to think about ideally what would we want to know as it relates to workforce diversity beyond demographics. Next slide, please.

So here you see a slide that was shared by the Diversity and Inclusion Management Program within the office. This slide is not meant to imply that these elements of diversity carry equal weight.

When Dr. David Williams came to CDC to present on diversity and health disparities, he presented four different ways of looking at diversity, and I will mention a couple just

because I want you to understand that this is not snowflake diversity.

Dr. Williams described snowflake diversity as the point of view that we are all individuals just like snowflakes. Because each person is unique, we should not attend to group differences in any substantive way. That is not what we are intending to communicate with this slide.

This slide gives the breadth of characteristics encompassed by diversity, and -- and I think our perspective would follow what he called critical diversity, which is the equal inclusion of people from all backgrounds.

So now, Dr. Jeff Hall will talk about aspects of diversity beyond characteristics, and these are other aspects that we would ideally want to measure.

DR. HALL: Thank you, Ana.

One of the reasons that we wanted to include this next section of slides in the

presentation is to give you an idea of the extent to which we are trying to get a good sense of what is involved in the measurement of diversity, as well as give you just a little bit of an idea as to how much of a challenge it is that we face when it comes to being able to move this project forward.

What you're going to see in the next couple of slides or so are simply an organizing tool. The charts themselves specifically represent some collective aspects of diversity that we saw emphasized and discussed and addressed in various ways in the literature, and also identified in a variety of different ways in association with the environment scan that we conducted.

As you might expect, the charts displayed there in the presentation contain the population characteristics that Ana just mentioned in association with the slide provided by the Diversity and Inclusion Office, but also

contain other elements that sometimes don't get considered when it comes to being able to have a more focused conversation about diversity and its measurement.

So in this respect, what we wanted to do is to provide just an idea of some of the things that were spoken to beyond those population-level characteristics, and specifically, we wish to just give you a brief bit of information about some of the structural, environmental, and competency-related elements that were touched on in various ways in the environmental scan.

So again, please keep in mind that this literature is very deep and very wide, so we wanted to give you just an idea as to some of the things that we saw in terms of the richness of the literature. So as an example of that first box that you see is dedicated to structural characteristics. We saw indicators examined such as representational measures, and in this

respect, that is denoted by the box, for cultural representation. And an example of one of the things that obviously has been captured in this domain are measures assessing the proportion of professionals from target groups in the workforce as a whole as well as in relation to their presence in specific professions.

With respect to concordance measures, we saw that the literature also emphasized the necessity of examining the proportion of professionals from target groups in relation to the proportional representation of those same target groups in the populations served.

And lastly, addressing one additional piece of this box of structural characteristics that we're focusing on here, it was emphasized that the presence and nature of inclusion-centered activities such as those focused on retention, recruitment, and training must be emphasized.

One other part that we thought should

be brought out in this presentation focuses on the component related to organizational governance, and more specifically, the subsections of literature that we found related to this part felt that it was very critical to examine representation of the entire group, not just in terms of their placement in front-line positions, but also across the various levels and layers and professional tiers as well as within supervisory and board-level positions within organizations and different occupational structures.

We saw in the literature that this was something that was very highly and strongly emphasized because those different levels of professional service have varying levels of involvement where participation in the making of critical decisions is concerned. So that was something that also was highlighted very significantly and very directly as a component of the organizational piece that requires some

attention.

And beyond just simply talking about representation, organizational structures were focused on with respect to characteristics such as the presence of policies, plans, strategies, and agendas that were diversity-focused and the extent to which the organizations in the professional context of operations took specific actions to advance or enforce diversity-centered activities.

With respect to the next element of the charts that we present to you, I think we can all agree that it's not just enough to focus on representation or to talk about the organizational structures within which people work. We also have to pay some attention to the actual climate or environment within which the work itself takes place.

So in this regard, some of the various measures of climate or environment that were identified included things such as the actual

movements of members of focal populations and the available career paths through organizational structures and within specific professions. One of the ways that this was tapped into was by examining the number or proportion of persons promoted from specific targeted groups or that were participating, for example, in specific types of career pathing programs.

We also saw and alluded to the fact that some emphasis was given to assessing the character of the climate by examining things such as the number of formal complaints that were submitted as well as obtaining some larger assessment of employee and management attitudes and practices as it relates to diversity issues.

So in this respect, beyond population characteristics and beyond structural characteristics, it has been emphasized that the climate is an essential component of what is captured where the measurement of diversity is concerned.

And lastly, we recognize that there is significant interest in competence and in how skilled personnel are with respect to the ability to render culturally and linguistically appropriate services. So one specific case of what we saw in the literature related some of the individual staff-level characteristics of persons providing health and healthcare services as well as organizational characteristics to aspects of the national CLAS standards.

And in this particular respect, the type of domains that were given attention included but were not limited to aspects such as leadership support, which, for example, is assessed by looking at whether organizational leaders and governing bodies actually value effective patient-centered communication, and whether the type of commitment that they exhibit something that is considered to be visible to both their lower-level staff as well as the clients that they serve.

A second example of one of the domains that received emphasis involves community engagement, and some of the questions posed with respect to the measurement aspects in that regard included whether or not there is demonstrable progress in terms of proactive efforts designed to effectively engage subgroups in communities where service is being provided.

Lastly, language services provision was a domain that received focus. In this particular respect, it was considered to be critical to take a look at the extent to which language assistance is required and rendered and how this relates to the ability of an organization to meet the needs of its service population.

So what we were trying to communicate in terms of providing the final portion of your presentation is a bit of information about the complexity of diversity measurement. We're not going to be able to, of course, with this

particular project get into all of those different dimensions and all these different aspects. But we wanted to be sure that you were aware that we examined these factors and tried to develop a feasible position with respect to how we would begin to move our project forward.

So at this particular point, I will turn the presentation back over to Ana, and we can deal with any additional questions you may have.

CHAIR RICHARDSON: Thank you for that. So is that the end of the presentation?

DR. PENMAN-AGUILAR: I can wrap up in 30 seconds.

CHAIR RICHARDSON: Okay, great.

DR. PENMAN-AGUILAR: Thank you so much, Jeff, and in terms of challenges we are facing, I would say certainly measurement gaps, places where data are not collected, would help us understand diversity better. Because of this, it will be difficult to get to more than just

certain population characteristics. Nevertheless, we are determined to have this be more than a snapshot of race, ethnicity, or race, ethnicity, and sex. We have some ideas that we will test out in the physician indicator development. And another challenge is just continued alignment with stakeholders, so we want to be in conversation with other stakeholders. Thank you.

CHAIR RICHARDSON: Are there questions for Ana or Jeff? Maybe I will start. I thank you for this very comprehensive presentation of the deep dive that you have taken into how to think about and look at and assess diversity, particularly in the context of the workforce. Can you maybe talk a little bit now about how you're going to operationalize this very impressive framework into metrics, and what are the next steps?

DR. PENMAN-AGUILAR: Well, I would say the first step is to do the teaser analysis

with physician diversity, and a lot of what we can do will be limited by the data that are available. So we will obviously have this entire framework in mind as we look at the data points that we have to work with, and we will try to do justice to the principles behind diversity in our measurement, but it will probably come down to the variables that we have, and we expect that we'll have race, ethnicity, sex, geography, and age, perhaps, so we would look at race, ethnicity, sex, and geography as dimensions of diversity.

I think one of the ways we could even use age or year of graduation from training would be to see whether our cohorts are becoming more or less diverse, so these are just some practical thoughts, and as Jeff said, when it comes down to the practicalities. However, we want you to know that we have not forgotten the other important things that Jeff has just shared with all of us.

DR. HALL: And one additional thing I will add -- and thank you, ladies and gentlemen. I know I flew through the presentation of the nuances of the framework. It helps to be able to lay out a lot of these conceptual parts because, as Ana mentioned, while there are going to be some obvious limitations with respect to what we can do with existing data, but having explored the literature and by beginning to create such a framework, allows us to also begin to develop some aspirational goals with respect to what might be possible to capture if opportunities were to present themselves for example to participate in new measurement activities where diversity is concerned.

So the framework that we presented has a lot of stuff in there that is abstract and that might be very difficult to measure within public health or even with respect to specific healthcare professions. But it helps to be able to think through the various pieces of diversity

and parts of diversity that together constitute the environment in which these professionals that render service perform, and it gives us a good position with respect to what we are measuring and how that relates to the actual realities that we're trying to change when we're pushing diversity as a social determinant of health.

DR. PENMAN-AGUILAR: Yes, and I would like to add to that, it's one thing we talk about in our team that what we can't measure may be just as important to understand as what we can measure. What we have done, we have actually created a matrix that has questions that we would want to answer if we had the data, and a lot of times, when you look at the cells that are filled in with the data sources, they're empty because the data just don't exist.

And, I also don't want to minimize the importance of doing better with population characteristics. This is something we have talked about at other meetings, that we really

need to do better as a field with getting to more of the characteristics that are listed in the framework.

CHAIR RICHARDSON: Okay. I want to leave some time for the committee members to ask questions --

DR. ROSS: This is Will Ross. I appreciate Lynne's question about how you are going to operationalize it because, you have quite a lot of data, and I understand that. Jeff, you have mentioned how much of this is abstract and how much of this is going to be spelled out later, but still, we don't have a sense of prioritization.

Among these -- within this framework, are there particular cells or areas that are going to be high priority based on the work that we presented -- the ACS recommendations we presented a couple years ago? So what will drive prioritization in this effort?

DR. PENMAN-AGUILAR: That is a very

good question. I would say that population characteristics are definitely a priority. I think anything that speaks to decision-making is a priority, since that is in the literature. Jeff, do you have anything to add?

DR. HALL: I do think that, like Ana said, the population characteristics and the decision-making piece are priorities. I think part of what we're beginning with is again limited by where we are starting. In characterizing the existing data sources, we are beginning from a position where we are essentially working with the decisions that people have made in the past, but what that may do is also create a space where we can then sort of say if we only focus at this part, then we're going to be very limited in how we can make movement forward in this particular space. That could in turn give us the ability to evaluate to what extent we could move into the examination of some of the other parts of this chart that we

have attempted to lay out for the group today.

DR. RO: This is Marguerite. I think the schema is really interesting, and it's one of the most organized schemas that I have seen, so thank you very much for doing this. I think this is actually in itself a contribution in addition to where there isn't data.

In terms of an interesting project that we might want to consider that would be another piece of information to add is many states through their Departments of Health have workforce plans that they are developing or have developed, and it would be interesting to look at -- for somebody like a graduate student or something, it would be interesting to look across state health workforce plans -- and to look at the areas that they touch under these schemas.

DR. HALL: I am glad you actually mentioned that because one of the activities that we did do as part of this work, when it came to some of the stakeholder conversations, we did

talk to Dr. Arlene Lester, who is one of the lead experts with respect to the CLAS standards, and in some of those conversations, Dr. Lester did talk to us, for example, about the accreditation boards that exist within public health and how relationships with those types of groups and looking at the work that they do in terms of compliance activities might provide us with some opportunities to get a sense of what is being done on the ground where some of the local health departments are concerned.

DR. WOOTEN: Hi. This is Wilma Wooten in San Diego. I am on the public health accreditation board, and I was thinking along those lines. If you could go into how to elevate or promote it as a national standard, it would be a great idea to connect with staff and communicate it to local public health jurisdictions because the workforce development plan is one of the required documents in the application process for a voluntary national

public health accreditation.

DR. PENMAN-AGUILAR: Great, and these are the types of intersections that we're wanting to think about right now, and I know Marguerite you had also mentioned some intersections with the de Beaumont Foundation and PH WINS, so we want to ensure that this is aligned, that we're learning from other people, that we offer value to others.

DR. WOOTEN: Yes. This is Wilma again. Both of those are organizations that have presented on diversity to the PH WINS project, so it would be really nice to avoid having competing models. They need to be integrated --

DR. PENMAN-AGUILAR: Okay.

DR. WOOTEN: -- in some way so that jurisdictions locally as well as states, territorial and trial jurisdictions are up to speed about what they should be focusing on. If everybody is in alignment, I think it would be a more coordinated approach, and we'll have overall

better outcomes at the local level in the public health jurisdictions monitoring this information.

DR. PENMAN-AGUILAR: Yes, and I hear my Director saying yes, yes, so that's a sign that I think we're onto something, and we will be wanting to communicate with others who have similar goals and assure that we're aligned.

DR. LIBURD: Wilma, this is Leandris. So we have started conversations with our colleagues here at CDC, Liza Corso, and the Public Health Accreditation Board, and Tiffany, so we will continue to actually raise this issue as well, talking with them primarily about health equity, and it will be on the agenda for our next meeting of the subcommittee, so we will continue this conversation.

CHAIR RICHARDSON: Okay, great. Anyone else? We are a little over time, but I think this is an important topic, and it has been a good discussion.

DR. GARZA: This is Mary. I just had a quick question: this is really interesting, this framework and everything, and I think this is really a contribution. Is there a timeline when some of these pieces are going to be operationalized and move forward? Do we have a deadline as far as getting this?

DR. PENMAN-AGUILAR: We want to have a report, some report, produced by the end of the year, and whether it's a report of a teaser analysis or beyond that, we want to present some data before the end of the year.

DR. GARZA: Okay.

CHAIR RICHARDSON: Thank you. Anyone else?

MR. VARGAS: This is Hector. I just want to add very quickly I concur with what my colleagues are saying about the contribution that this work is doing.

Just a suggestion if it is not already included to specifically call out gender identity

in the analysis. I am certain that is probably part of the --

DR. PENMAN-AGUILAR: Absolutely.

MR. VARGAS: -- data gaps, so I think that is important because sexual orientation is already there, and I think that is important. And secondly, just to sort of reaffirm the importance of the gap analysis that you're going to do, and I hope that that gap analysis will include specific recommendations on how we can try to fill in those gaps where data does not exist or very little data exists.

DR. PENMAN-AGUILAR: Thank you, Hector, and that is at the very top of our list in terms of gaps, gender identity and sexual orientation.

CHAIR RICHARDSON: Okay. Well, thank you, Ana and Jeff. We look forward to continuing to hear on the progress as you move this forward.

DR. HALL: Thank you.

CHAIR RICHARDSON: And it is very

important work and quite promising in the very thorough and comprehensive approach that you have taken.

So we have moved down the agenda. We're now at the open discussion period, and so Wilma, I know there is an item that you had wanted to bring to the HDS from the SDOH Think Tank.

DR. WOOTEN: Sure, thank you, Dr. Richardson.

So the Social Determinants of Health Think Tank had a meeting last Friday, and there was a lot of discussion about making recommendations to the Director or Interim Director. For example, making explicit recommendations about preserving and continuing the health equity and social determinations of health efforts, and identifying strides that have been made, and clarifying why we want to continue.

This is an opportunity to present a united voice to push for ensuring that those

efforts continue. The discussion was, because we were having this meeting today, to bring the sentiments of the SDOH Think Tank to this group to request that a joint letter or recommendation be developed, and that is the first ask. Does this subcommittee want to do that? And if so, to form an ad hoc group to determine the content, and then that group would also bring back some strategic approaches, whether to send the recommendation to the current Interim Director or wait for the permanent Director to come onboard.

There were two components that received a lot of discussion. Particularly, whether it is advantageous to send information now as well as when a new Director comes in, or wait until a permanent Director comes onboard? This is my proposal to the subcommittee.

CHAIR RICHARDSON: Comments, discussion? I know some of you will recall we did have a similar discussion at our last meeting

about putting together something, whether it was a letter or a report, but something to put in front of the new leadership of CDC, so I think we are very much on the same page with the work group.

I guess the questions are: Is this something the HDS wants to move forward with? And should we do it in concert with the Social Determinants of Health Think Tank?

DR. Iton: This is Tony Iton. I support that invitation that we should do it in concert with that work group, and I think that we should wait, and I suspect that we won't have to wait that long.

CHAIR RICHARDSON: Yes, for a permanent Director of CDC?

DR. ITON: Yes.

DR. ROSS: This is Will. I agree with Tony Iton. I think that we want to wait for maximal impact and maximal effect, and I do think that we should speak with one voice, and so I

would urge us to have a unified document.

DR. RO: This is Marguerite. I second that.

CHAIR RICHARDSON: Okay. I am definitely hearing a rapidly forming consensus. Leandris, I guess a question I have for you is, or Wilma, if this was discussed, would this be most impactful if the think tank and this subcommittee worked together to create a document which we then present to the ACD for its endorsement so that it actually came from the full ACD rather than the subcommittee and think tank? Is that --

DR. WOOTEN: That was the intent, Lynne, yes.

CHAIR RICHARDSON: Okay. So Leandris, if the ACD meeting occurs in April, at what point would the agenda close? Just so we know, can we still get onto the April meeting agenda?

DR. LIBURD: Yes. The agenda doesn't

close until generally 30 days before the meeting, and we have had a standing spot on the agenda for the Health Disparities Subcommittee --

CHAIR RICHARDSON: On the agenda?

DR. LIBURD: Yes, on the agenda, so --

CHAIR RICHARDSON: So it could be presented at that time?

DR. LIBURD: Yes.

CHAIR RICHARDSON: Okay. And it could be also referenced in the field report as well.

DR. LIBURD: Exactly, but deferred, that the full report would come with your report.

CHAIR RICHARDSON: Very good. Are there any questions or concerns about the course of action upon which we seem to be embarking?

(No audible response.)

CHAIR RICHARDSON: Anyone?

(No audible response.)

CHAIR RICHARDSON: All right. So I

think now what we need are a couple of individuals who will actually do the work of drafting a document that could then be circulated for review by both groups, presumably. Wilma, do you have a working draft, yet?

DR. WOOTEN: No, no working draft. I think we thought about pulling from some of the prior recommendations --

CHAIR RICHARDSON: Yes.

DR. WOOTEN: -- and then wherever there were any gaps, sentiments that we wanted to move forward, we would include that as well, but our recommendation or suggestion was to form this ad hoc group. I am thinking the chairs of the Social Determinants of Health Think Tank plus the chairs of the subcommittees, STLT Subcommittee and Health Disparities Subcommittee, and anyone else who would want to be involved. We can maybe align it with some of the upcoming meetings, and I know that you have some additional meetings coming up.

CHAIR RICHARDSON: Right. Well, I am happy to personally be involved. I certainly would like to have at least one more volunteer from the subcommittee because I do not want to become the rate-limiting step to this process.

DR. WOOTEN: Yes, absolutely. And that is a decision that doesn't need to be made now, but could be made --

CHAIR RICHARDSON: Yes. Well, I actually would like to get a sense of who is interested or willing to volunteer now, and then we can follow up with you and try to convene a meeting of --

DR. WOOTEN: Absolutely.

CHAIR RICHARDSON: -- whoever it is who is going to be involved and figure out the process and a timeline. Certainly I think we all would like to have this ready to present to the ACD at its April meeting, so I think that is the most important timeline.

DR. WOOTEN: Let's just assume that

the permanent Director will not be onboard, is that what we're thinking, for April, or do you think that they would be?

CHAIR RICHARDSON: No, we think they probably will not be.

DR. WOOTEN: Yes.

CHAIR RICHARDSON: I guess my thought was that we should have it ready to go to be presented to the Director as opposed to waiting until there is a Director and then starting to write it --

DR. WOOTEN: Oh --

CHAIR RICHARDSON: -- and get --

DR. WOOTEN: -- absolutely --

CHAIR RICHARDSON: -- ACD approval.

DR. WOOTEN: Starting now is absolutely the intent. Where I was going was to make the recommendation to the ACD, and the ACD would present it to the permanent Director when they are onboard.

CHAIR RICHARDSON: Yes, that seems to

be the strong consensus of the HDS that we would like to wait and present these recommendations to the permanent Director.

Okay. Any other comments? I guess we should anticipate for the possibility that we might need to modify them if there is some important change after we have a working draft, but I think that is relatively easy to do, but I don't want to wait and try to get approval at the October ACD meeting because then I feel like we may have missed the opportunity, you know.

DR. WOOTEN: I was not even insinuating that.

CHAIR RICHARDSON: Right, right, no, I understand, yes. But there is a possibility which was mentioned at the beginning of our call that the April meetings which include both this subcommittee and the ACD might be rescheduled if we are close to having a new Director come onboard because it might be beneficial to have the new Director at the meeting, so right now we are

holding the April date, but we will put everyone on notice that the date may change if say by May there would be a new Director in place. Maybe then the ACD meeting would be pushed back, so that's a possibility.

DR. WOOTEN: Certainly, but we can still get the work done --

CHAIR RICHARDSON: Exactly. And I think the bulk of what we're going to say is not going to change over the next few months.

DR. WOOTEN: Right.

CHAIR RICHARDSON: Okay.

DR. RO: Well Leandris, this is Marguerite. I would be happy to join that phone call.

CHAIR RICHARDSON: Excellent.

DR. ROSS: Well Marguerite, you and I are joined at the hip, and so if you join, I will be there.

DR. RO: I think Will and I are two of the departing members, so this can be our

parting shot, as it were?

CHAIR RICHARDSON: Yes.

(Laughter.)

CHAIR RICHARDSON: Okay. I don't want to make it too big, and we certainly will take whatever draft is developed and bring it back to the whole HDS. We have another call before April, Leandris?

DR. LIBURD: We actually do not.

CHAIR RICHARDSON: Okay. Well, I feel though like we could do it by email, and if we have to schedule a call for purposes of discussing this document, then we might be able to do that on an ad hoc basis, but I would like to get input from the entire subcommittee. Well, I guess we would be meeting before the ACD, is that right? Yes.

DR. LIBURD: The office can coordinate the calls for the three of you, or however many will be part of the initial writing, and, we can provide a conference call number --

CHAIR RICHARDSON: Right.

DR. LIBURD: -- so we can have time to get meetings on people's calendars, we just need to confirm from that it is Will, Marguerite, you (Lynne), and I don't know who else?

CHAIR RICHARDSON: Whoever is coming from the SDOH Think Tank, and perhaps the --

DR. WOOTEN: So it would be myself, the chair of the think tank, and then I would imagine we would probably solicit one or two other people, and we'll get that information to you through Judy.

CHAIR RICHARDSON: Very good.

DR. LIBURD: I think we could get people's schedules within the next month? Okay?

CHAIR RICHARDSON: Okay. I do want to take this time to declare the opening of the public comment period. Are there any members of the public on the phone who would like to announce themselves and address the committee at this time?

MS. RICHARDS: Lynne, this is Judy Richards. I just wanted to add one piece of information since this is an open time, but the STLT Subcommittee is actually meeting on the 21st of March, so you might want to consider that in your timing. That is all.

CHAIR RICHARDSON: Thank you for that. Okay, one more time, here is the opportunity for members of the public who are on the phone who would like to address the committee.

(No audible response.)

CHAIR RICHARDSON: Okay. I see we are right at the hour, and so I don't want to hold people to make fatuous closing remarks. I think we have heard about some very important initiatives during this call, and we have taken on one action item, which I think we're quite committed to, and we will keep you updated on that and also on any potential changes to the meeting date in April. So unless somebody has

something else urgent, with that, I will adjourn the meeting and bid you all a good afternoon. Thank you.

(Whereupon, the above-entitled matter went off the record at 3:01 p.m.)